



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

DAVID A WEST DO  
3100 TIMMONS LANE SUITE 250  
HOUSTON TX 77027

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

VIA METROPOLITAN TRANSIT

#### **Carrier's Austin Representative Box**

Box Number 16

#### **MFDR Tracking Number**

M4-12-0996-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary as taken from the Table of Disputed Services:** "Carrier refuses to pay full amount due for services rendered, even after a request for reconsideration was submitted."

**Amount in Dispute:** \$70.04

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "On January 3, 2011 Medicare implemented the multiple procedure payment reduction (MPPR) for selected therapy services. Reference the enclosed MLN Matters number MM7050 revised, which states for selected procedures codes full payment is made for the unit or procedure with the highest PE payment... The enclosed list indicates procedure code 97750 is subject to the multiple procedure payment reduction. The Medicare reduced therapy fee for this code is \$27.52. This value multiplied by the approximate DWC markup of 1.605 is \$44.18. Therefore, the calculation is as follows:

97750-(one unit=100% of MAR) =\$48.70

97750-(15 units x \$44.18) =\$662.70

The prior total reimbursement of \$711.40 is correct and no additional allowance is due."

**Response Submitted by:** Argus Services Corporation; 811 S. Central Expwy- Suite 440; Richardson TX 75080

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 6, 2011	97750-FC	\$70.04	\$67.84

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.204 set out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.

3. The service in dispute was reduced by the respondent with the following reason codes:

Explanation of benefits dated May 18, 2011

• 59J —Processed based on multiple or concurrent procedure rules, \*Practice expense component for select therapy services reduced by 20% for non-facility and 25% for facility.\*

Explanation of benefits dated June 22, 2011

• 193 —Original payment decision is being maintained. Upon review, It was determined that this claim was processed properly.

• 59J —Processed based on multiple or concurrent procedure rules, \*Practice expense component for select therapy services reduced by 20% for non-facility and 25% for facility.\*

### **Issues**

1. Did the respondent support denial reason code '59J'?
2. Has the requestor been reimbursed appropriately for a Functional Capacity Evaluation (FCE)?
3. Is a Functional Capacity Evaluation reimbursed like a therapy code?
4. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The respondent reduced the payment of the disputed service based on denial reason '59J' - Processed based on multiple or concurrent procedure rules, \*Practice expense component for select therapy services reduced by 20% for non-facility and 25% for facility.\* The respondent's position summary states "On January 3, 2011 Medicare implemented the multiple procedure payment reduction (MPPR) for selected therapy services. ... The enclosed list indicates procedure code 97750 is subject to the multiple procedure payment reduction..." This denial reason is not supported because 28 Texas Administrative Code §134.204 (a) states, "Applicability of this rule is as follows: (5) Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program." The procedure code in dispute, 97750-FC, falls into this exception. Therefore, this review will be in accordance to the applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.204 (g) states, "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c) (1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:
  - (1) A physical examination and neurological evaluation, which include the following:
    - (A) appearance (observational and palpation);
    - (B) flexibility of the extremity joint or spinal region (usually observational);
    - (C) posture and deformities;
    - (D) vascular integrity;
    - (E) neurological tests to detect sensory deficit;
    - (F) myotomal strength to detect gross motor deficit; and
    - (G) reflexes to detect neurological reflex symmetry.
  - (2) A physical capacity evaluation of the injured area, which includes the following:
    - (A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
    - (B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.
  - (3) Functional abilities tests, which include the following:
    - (A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
    - (B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and

manipulation tests using measuring devices;

(C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and

(D) static positional tolerance (observational determination of tolerance for sitting or standing).

3. An FCE is billed and reimbursed in accordance with 28 Texas Administrative Code §134.203(c) (1), however, an FCE is a Division-specific code with a Division-specific modifier (97750-FC) defined as a comprehensive evaluation focusing on measuring the patient's functional abilities (potential for work). CPT code 97750 (physical performance tests/measurements) is classified as an 'always therapy' code used to evaluate the patient's performance of a specific activity/group of activities (to assess physical capabilities). Therefore, the FCE is not subject to the Medicare payment provision of a multiple procedure payment reduction for selected therapy services.
4. Additional reimbursement is recommended as follows:  
(DWC conversion factor \$54.54 divided by Medicare conversion factor \$33.9764 = \$1.61) x participating amount \$30.34 = \$48.7027 x 16 units = \$779.24 (MAR) minus respondent's previous payment of \$711.40 = \$67.84 due to the requestor.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$67.84.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$67.84 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ March     , 2012 Date
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### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefieres hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**